Department of Medical Assistance Services

Strategic Planning

Fiscal Years 2007 & 2008

Part A
Overview

DMAS Agency Strategic Plan
Part A - Overview

Table of Contents

Agency Strategic Plan

Department Of Medical Assistance Services

Agency Mission, Vision, and Values

Mission Statement:

To provide access to a comprehensive system of high quality and cost effective health care services to qualifying Virginians.

Agency Vision:

DMAS will become a recognized leader in the administration of health care programs in Virginia and among state Medicaid agencies.

Agency Values:

- **Operate with a high degree of customer service.**
- **Demonstrate integrity, respect, responsiveness and competency in our actions and communications.**
- **Foster an atmosphere of effective collaboration with our customers and stakeholders.**
- **Encourage innovation and require accountability.**

Agency Executive Progress Report

Current Service Performance

During the past four years, the priority objective for the Department of Medical Assistance Services (DMAS) was to increase enrollment in Virginia's health insurance programs for children. DMAS has met this challenge As a result of administrative and operational improvements in the programs and intense outreach efforts, more than 142,000 additional children have been enrolled in either Medicaid or the Family Access to Medical Insurance Security (FAMIS) program. Based on current estimates, 98% of the children eligible for these programs are now insured.

In addition to turning around children's health insurance, DMAS has been working to make Medicaid a more cost-effective program. Pharmacy expenditures represented the fastest growing component of Medicaid spending in previous years. To control these costs, DMAS successfully implemented several cost-containment programs that reduced the annual increase in prescription drug costs from 12% to 3%. Equally important, our customers continue to receive high quality prescription drug coverage. Also, DMAS has expanded its managed care programs by approximately 34,568 customers in the Northern Virginia and Winchester areas to control costs and improve quality of care. Other programs that are being implemented to improve the level and quality of services provided to our customers include a new pediatric dental program, a disease state management program, and new and expanded programs for special populations, known as "waiver programs."

Virginia was one of the first states in the country to respond to the health care needs of Hurricane Katrina evacuees. DMAS implemented a special health benefits program, called E-Medicaid, for Katrina evacuees who came to Virginia. The new program was established within 48 hours of receiving authority to do so. From September, 2005 through March, 2006, DMAS' E-Medicaid program provided health benefits to approximately 4,000 evacuees.

The Medicare Part D prescription drug program was implemented by the federal government on January 1, 2006. Among those affected by the new program are approximately 100,000 "dual eligible" clients enrolled in both Medicaid and Medicare. Due to the many implementation problems associated with the Part D program, Governor Kaine authorized DMAS to pay for prescription drugs for the dual eligibles when efforts to bill the Part D program failed. From January 1, 2006 through March 8, 2006, DMAS paid a total of $5.5 million for 86,526 claims on behalf of 27,854 clients.

DMAS also has been working diligently to improve its customer service. We have made great strides in working with and involving various stakeholders (e.g., providers and advocacy groups) in the development and implementation of agency programs and activities. In addition, the performance of the agency's call center has improved markedly in the past year, which enables the agency to provide better customer service to providers and enrollees.

For the future, the agency and the Commonwealth's resources dedicated to its programs will continue to be pressed. In 1995, Virginia Medicaid provided coverage to approximately 681,000 recipients, representing about 27% of all persons who lived below 200% of the federal poverty level (FPL). Within ten years, coverage increased to include more than 832,000 recipients, representing approximately 30% of all persons living below 200% FPL. Efforts to control costs while maintaining quality health care coverage will continue to be a high priority for the Department.

Productivity

DMAS strives to be an efficient and effective organization. Currently, DMAS uses several high level measures to track the overall productivity of our agency. These measures well-illustrate DMAS' increased efficiency in recent years.

Note: Each measure described in this section has a graphic component that can be found in Appendix B.

Medicaid Recipients per DMAS Employee

• Purpose and explanation: This statistic shows the number of people actually receiving services in a given year in the Medicaid program compared to the maximum number of DMAS employees, as measured by the maximum employment level (MEL).

• Results: This measure has increased from 1,828 recipients per employee in FY 1998 to 2,358 in FY 2005. This is a 29.0% overall increase in customers per employee in the seven year period. With the number of employees remaining relatively constant, this illustrates our overall increased efficiency of work over this period.

Net Administrative Expenditures per Total Expenditures

• Purpose and explanation: This measure shows Medicaid administrative expenditures by year compared to the total Medicaid expenditures.

The net administrative expenditures exclude highly variable expenditures of transportation (which actually is a program service/benefit provided directly to clients) and information technology (expenses were unusually and significantly higher during the past few years due to the design and implementation of an entirely new Medicaid Management Information System - MMIS). Both sets of expenditures also exclude the intergovernmental transactions (IGT)/ revenue maximization.

• Results: Net administrative expenditures per total expenditures have decreased from 2.03% in FY 1999 to 1.31% in FY 2005. This reflects a 35.6% decrease in this important overall measure. We are efficiently using our resources.

Medical Expenditures per Net Administrative Expenditures

• Purpose and explanation: This measure is similar to the above; however, it illustrates the ratio of medical expenditures only to the net administrative expenditures, defined above.

• Results: Medical expenditures to net administrative expenditures have increased from a factor of 48.2 in FY 1999 to a factor of 75.3 in FY 2005. This is a 56.4% increase.

Home and Community Based Care Waiver Enrollment per Long Term Care Staff

• Purpose and explanation: This measure compares recipients in the Home and Community Based Care waivers to the number of staff dedicated to the Home and Community Based Care waivers.

• Results: In FY 2000, there were 1,400 recipients in the Elderly or Disabled with Consumer Direction Waiver, or the AIDS waiver for every dedicated staff person. In 2004, the enrollment per staff had grown to over 1,809, or a 29% growth

Major Initiatives and Related Progress

The Medicaid program is very large and complex and has many different components and activities. DMAS has implemented several major initiatives to improve the quality and cost-effectiveness of Medicaid as well as FAMIS. DMAS will be embarking on several additional initiatives in 2006 and 2007.

Behavioral Pharmacy Management Services (BPMS)

The Department's newest pharmacy quality initiative, whose focus is on behavioral health medications, identifies prescribing patterns that appear to deviate from best practices. Providers are informed of the variations that relate to their patients and are offered expert consultation, if desired. The initial analysis of behavioral pharmacy claims resulted in letters being sent to outlier prescribes that involved over 37,000 recipients (39% of all recipients receiving designated behavioral health medications), and more than $17 million in drug spending (40% of total spending for these drugs). It is too early to identify any specific quality interventions or savings from this program.

Smiles for Children Dental Program

DMAS implemented its new Smiles for Children dental program on July 1, 2005. Smiles for Children consolidates dental services provided to Medicaid and FAMIS children under a single administrator to improve access to and utilization of pediatric dental services. Numerous other changes were included in the new program to make it more "provider-friendly" and to reflect industry-standard processes for administering dental benefits. The new program has been highly successful: an additional 160 dentists have enrolled; the percentage of enrolled providers who are treating Medicaid/FAMIS children and filing claims has increased 25%; and initial utilization data indicate more children are accessing dental services.

FAMIS MOMS

Effective August 1, 2005, DMAS implemented a new program called FAMIS MOMS that expands Virginia's Title XXI program to pregnant women. The 2005 General Assembly appropriated funding to expand coverage from the current Medicaid income level (133% FPL) to 150% FPL. Women enrolled in FAMIS MOMS will receive Medicaid benefits for the duration of their pregnancies and for two months postpartum. Women can apply for FAMIS MOMS by phone through the FAMIS Central Processing Unit (CPU), on-line at www.FAMIS.org, or through their local departments of social services. Most women will receive medical services from a contracted managed care organization and early and continuous prenatal care will be strongly encouraged. As of April, 2006, a total of 414 women have received services from the program.

Long Term Care Waivers

As a result of actions taken by the 2005 General Assembly, DMAS is implementing two new waiver programs, a Day Support Waiver and Alzheimer's Waiver. The Day Support Waiver, which was implemented on July 1, 2005, provides day support and prevocational services to 300 people with mental retardation who could otherwise be admitted to Intermediate Care Facilities for the Mentally Retarded. The Alzheimer's Assisted Living Waiver provides services in assisted living facilities for 200 people who are 55 and older, who have Alzheimer's, who receive an Auxiliary Grant, and who might otherwise be admitted to nursing facilities. There are three approved providers for this waiver. DMAS currently is beginning the process of notifying providers and potential recipients of the start up of this waiver.

Medicare Part D

The new Medicare drug benefit (Part D) became effective on January 1, 2006. As a result of this program, approximately 100,000 current recipients enrolled in both Medicare and Medicaid (dual eligibles) began receiving their pharmacy coverage through Medicare as opposed to Medicaid. The national implementation of

this federal program was wrought with problems. While numerous problems occurred in Virginia, the magnitude of problems was far less than what was experienced in other states. This was due in large part to the extensive start-up efforts and preparations by DMAS, other state agencies, the Virginia Pharmacists Association and many other partners. Most of the initial implementation problems have been resolved; however, lingering issues still require a substantial commitment of DMAS resources to this federal program.

Disease State Management (DSM) Program

DMAS implemented its DM program, Healthy ReturnsSM on January 13, 2006, for persons enrolled in its fee-for-service program who have one or more of the following chronic health conditions: asthma, diabetes, congestive heart failure (CHF), and/or coronary artery disease (CAD). Healthy ReturnsSM provides patient-focused services to help members manage their chronic health condition(s), avoid more costly treatments, and remain healthy.

Healthy ReturnsSM was first implemented as a pilot program in June 2004. Health Management Corporation, a wholly owned subsidiary of Anthem Health Plans, offered the pilot program at no cost to DMAS for eligible Medicaid fee-for-service participants diagnosed with CAD and/or CHF. Clinical outcomes indicated that the Healthy ReturnsSM pilot program positively affected members' health status and utilization of services. Overall, the level of members' health quality improved in nine of twelve clinical outcomes. Members made improvements in their ability to manage their own self-care and in their clinical test scores. The Healthy ReturnsSM pilot program encouraged optimization of service utilization by supporting drug regimen adherence and preventive care. Improvements in service utilization were indicated by a 5% reduction in hospital inpatient admissions and an 11% decline in the number of days members spent in the hospital.

Managed Care Expansions

DMAS continued to increase the number of persons enrolled in managed care plans. Effective September 1, 2005, AMERIGROUP began operations in Northern Virginia adding 19,038 clients to the total number of managed care enrollees. In addition, there were 6,455 additional clients that enrolled with the existing Northern Virginia managed care plan during the expansion. On December 1, 2005, DMAS extended managed care to another 9,075 enrollees in the Winchester area of the state. In addition to the Northern Virginia and Winchester expansions, DMAS will be increasing the number of enrollees in its managed care program through planned expansions in other parts of the state during 2006 and 2007. DMAS also plans to increase the different types of enrollees participating in managed care such as those in long-term care settings.

Medicaid Reform

Controlling the growth of Medicaid expenditures and maintaining high quality care for those eligible for Medicaid have received significant attention within the Commonwealth and across the nation. The 2006 Session of the General Assembly passed legislation directing DMAS to convene a Medicaid Revitalization Committee to review various potential reforms to Medicaid, and to report its recommendations to the General Assembly by December 1, 2006. On the national level, the Deficit Reduction Act of 2005 includes numerous substantial changes to state Medicaid programs. Some of the changes are mandatory while others are optional for the states. A key initiative for DMAS during 2006 will be to develop proposed strategies that respond to the state and national calls for Medicaid reform.

Integration of Acute Care and Long-Term Care

One of Governor Kaine's key initiatives for DMAS is to develop a blueprint for integrating acute care and long-term care services for Medicaid clients. The plan will be developed during 2006 with the input of all major stakeholders. Concurrent with the development of the long-range plan, DMAS will move forward with two models of care: (i) establishment of Program for All inclusive Care for the Elderly (PACE) sites across Virginia;

and (ii) regional managed care plans that include acute and long-term care services.

Increased Emphasis on Electronic Processing Systems and Program Integrity

Increasing the efficiency of the Virginia Medicaid program by maximizing the use of electronic systems to process claims, reimburse providers, prior-authorize services, and perform other administrative tasks will be a major focus for DMAS during 2006. The agency will be working to increase the number of providers able to submit claims and receive reimbursement electronically. Also, the Department's prior-authorization program is being totally redesigned to include on-line mechanisms for prior-authorizing services and minimizing paper- and staff-intensive processes.

During 2006, DMAS also is making a major push to increase its program integrity efforts. A new contract for conducting compliance audits for home health, home infusion services, pharmacy, durable medical equipment, and other services were awarded in May 2006. The efforts of this contractor provides a significant "return on investment" and improves the integrity of Medicaid payments in this area.

Implementation of Agency Risk Management and Internal Control Standards

In October 2005 the Virginia Department of Accounts issued its Directive Number 3-05: Required Implementation of Agency Risk Management and Internal Control Standards. In accordance with the Directive, each Virginia State agency must plan and take systematic, proactive measures to (a) plan, develop, and implement a comprehensive and cost effective risk management program to support its performance management program; (b) assess the adequacy of internal controls in all agency services, operations, and activities; (c) identify needed improvements; (d) take corresponding preventative and corrective actions; and (e) report annually on internal control. Each agency must publish a comprehensive 3-05 implementation plan no later than June 30, 2006; the directive's full requirements must be met in full by June 30, 2007. The mandates included in this directive are similar to the mandates required of publicly traded companies from the Sarbanes-Oxley Act of 2002.

In response to this directive DMAS' Internal Audit Division has designed a three year audit plan, beginning in 2006, which will support the agency's compliance with the directive. In addition, DMAS is in the process of procuring consulting service with experience in developing a risk management program to work with DMAS' recently formed Agency Risk Management Compliance Team in developing the implementation plan by the spring of 2006.

Virginia Ranking and Trends

Virginia Medicaid historically has been one of the leanest programs in the nation. Data gathered from the National Association of State Budget Officers (NASBO) for FY 2003 showed the following:

• Compared to other states, Virginia had the smallest percentage of its state population (7.3%) enrolled in Medicaid, giving Virginia the 50th rank in the nation. Comparatively, in Federal Fiscal Year 2000, Virginia ranked 47th in Medicaid recipients as a percentage of total population. Note: A first place ranking is assigned to the state with the highest percentage of its population enrolled in Medicaid.

• Medicaid acute care and long-term care costs were $2.0 billion and $1.4 billion or 55.4% and 38.8% of total Medicaid expenditures, respectively. Consequently, Virginia ranked 28th and 31st in acute and long-term care spending nationwide, and 8th and 5th within the 12 southeastern states. Note: A first place ranking is assigned to the state with the highest costs.

• Total Medicaid expenditures were approximately 13.4% of overall state expenditures. Virginia ranked as the 6th lowest state in the U.S. with respect to Medicaid costs as a percentage of total state expenditures. Note: A first place ranking is assigned to the state with the greatest percent of overall state expenditures devoted to Medicaid.

It must be noted that due to the wide variations among state Medicaid programs and reporting methods, there are inherent limitations with any national rankings. The above rankings must be viewed in this context

Customer Trends and Coverage

The Department provided services to over 978,000 persons during fiscal year 2005. General population growth in Virginia and especially the growth of the aging population are key factors affecting the Department's customer base. The number of Virginians age 65 and older is projected to increase dramatically over the next ten years – over five times faster than the state's total population growth. An aging population within the state will place increased demands for services on Medicaid, especially in the areas of long-term care and waiver services.

Access to medical care for uninsured children has been a priority of DMAS. Since 2002, the number of children served through the FAMIS and FAMIS Plus (Medicaid for Children) programs has grown over 40% as a result of program reforms and aggressive outreach campaigns. Given the fact that approximately 98% of eligible children are now covered under FAMIS and FAMIS Plus, DMAS expects future growth in the program to slow.

The enhanced ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department's customer base.

Economic conditions also affect the number of individuals eligible for medical assistance services and other programs administered by the Department. Should there be continued economic growth in the Commonwealth, there would be a countervailing trend that would be expected to reduce the number of low-income Virginians, and, in turn, the number of individuals needing medical assistance and other services provided by DMAS.

Overall, DMAS' 2005 Consensus Forecast projects slowing growth in the number of persons covered by the Medicaid program. The decline in enrollment growth is as follows: 9.1% in FY 2004; 7.6% in FY 2005; 5.3% in FY 2006; 3.4% in FY 2007; and 2/7% in FY 2008.

See Appendix C for graphs.

Future Direction, Expectations, and Priorities

The future direction for DMAS will be to monitor the effectiveness and impact of recent program enhancements and initiatives, and to be proactive in the administration of the program by adjusting current activities and implementing new enhancements that improve the services we provide to our customers.

There are several factors that will impact Virginia Medicaid in the future including: (i) the aging population, especially those age 85 and older; (ii) an increase in the number of persons with disabilities seeking services; (iii) new technology requirements such as electronic health records, HIPAA (Health Insurance Portability and Accountability Act) compliance and the National Provider Identifier project; and (iv) continued growth in overall program enrollees and costs.

Perhaps the most significant issue is the current Medicaid reform efforts underway both in Virginia and in Washington. The 2006 Session of the General Assembly has directed DMAS to convene a Medicaid Revitalization Committee to make recommendations on various Medicaid reform strategies. Also, the federal Deficit Reduction Act of 2005 includes numerous changes to Medicaid programs across the country. Many of the federal reform changes are mandatory, and states must enact them. In addition, there are a number of "optional" changes that states may implement. Two of the optional changes that have the potential to significantly impact the operation of Medicaid in Virginia are increased cost sharing and potential benefit reductions. Regarding cost sharing, unlike the current co-payment policies, states have the option of making co-payments enforceable. This means that if a recipient does not pay, the provider will have the option to deny services. Virginia will need to weigh the advantages of charging higher co-payments and offering limited benefit packages against the disadvantages that would likely manifest in care access problems for Medicaid recipients and greater use of emergency rooms for routine care. The future direction of Virginia's Medicaid program will depend largely on decisions that are made in response to the call for Medicaid reform.

Agency Priorities

The following are among the top priorities for DMAS in the future.

- Responding to state and national Medicaid reform issues;
- Developing a blueprint for integrating acute and long-term care services;
- Expanding managed care enrollment to include new geographic areas and populations;
- Increasing retention efforts to keep eligible children enrolled in Medicaid and FAMIS;
- Enhancing the Department's capabilities and activities in preventing, identifying, and eliminating fraud and abuse;
- Improving the effectiveness of waiver programs serving the elderly, and persons with mental retardation or other disabilities, and developing Program for All Inclusive Care for the Elderly (PACE) sites;
- Monitoring the new dental program and making any needed adjustments to improve access to care;
- Increasing the use of electronic systems to improve internal processes and administrative efficiencies;
- Improving SWAM Contracting and Purchasing and
- Develop a comprehensive Agency Risk Management program which will assist agency management in administering DMAS' programs while adequately protecting the Commonwealth's resources.

Impediments

Expenditures

Total fund expenditures for the Medicaid and FAMIS health care programs have increased from $2.753 billion in FY 2000 to $4.506 billion in FY 2005, an average annual rate of increase of 10.4 percent. This increase has occurred despite several savings initiatives that were implemented to reduce costs. As these programs continue to grow and represent an even larger share of the state budget, it will be difficult for the Commonwealth to continue to provide full funding for the program. However, without these resources, the agency will be unable to maintain the level of services offered to its customers.

Maximum Employment Level (MEL)

As the agency's programs continue to grow, there is an increased strain on DMAS' limited administrative resources, particularly its staff. The number of clients served has swelled over the past several years; however, the agency's MEL has remained relatively constant. This has placed extreme hardships on current staff that is asked to do more and more with little or no additional help. Without an increase in MEL, it will be exceedingly difficult for DMAS to meet its current service obligations, and nearly impossible to expand existing programs or add new services or activities.

Provider Reimbursement

DMAS relies on its contracted health care providers to deliver services to our customers. While there are some provider groups that often receive some level of increase in reimbursement (e.g., hospitals and nursing homes) and some that recently have received substantial increases in reimbursement (e.g., physicians providing obstetrics/gynecology services, dentists), some provider groups have received very modest increases over the past several years. Without increases in reimbursement for several provider groups, access to care will decline for our patients as providers make business decisions to no longer participate in Medicaid or FAMIS. Also, even for those providers who have received increases, they are still paid well below the amounts paid by commercial insurers. Without an annual inflation factor or other type of routine adjustment, provider reimbursement will continue to be an impediment to providing needed services to our customers.

Agency Background Information

Statutory Authority

DMAS comprises 13 specific service areas to accomplish the mission of the agency. The statutory authorities under which the service areas exist are presented below.

Involuntary Mental Commitment Fund (32107) - Code of Virginia §37.1 – 67.4

FAMIS (44602) - Federal: CFR 42 part 457; Code of Virginia §32.1-351

State Mental Health and Mental Retardation Facilities (45607) - Federal Legislation: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10

Mental Health Mental Retardation Services (45608) - Federal Legislation: Title XIX of the Social Security Act and CFR 42 part 440; Code of Virginia: Chapter 32.1, Chapter 10

Professional & Institutional Medical Services (45609) Federal Legislation: Title XIX of the Social Security Act; Code of Virginia: Chapter 32.1, Chapter 10

Long Term Care Services (45610) - Code of Virginia: Title 32.1, Chapter 10

Indigent Health Care Trust Fund (45901) - Code of Virginia: §32.1-332 et seq.

Regular Assisted Living Program (46105) - 12 VAC30-120-460

State and Local Hospitalization Program (46401) - Code of Virginia: Title 32.1, Chapter 12

Insurance Premium Payments for HIV-Positive Individuals (46403) - Code of Virginia: § 32.1-321.2 through 32.1-321.4, and § 63.1-124

Uninsured Medical Catastrophe Fund (46405) - Code of Virginia §32.1-324.3 and § 32.1-325

Medicaid SCHIP (46601) - CFR: 42 part 457; Code of Virginia §32.1-351

Administrative & Support Services (49900) - 12 VAC30-120-460

Customer Base:

Customer Description	Served	Potential
FAMIS	71,589	0
HIV Premium Assistance Program	78	0
Involuntary Mental Commitment Fund	8,392	0
Medicaid (adults) and FAMIS Plus (children)	832,905	0
Medicaid Expansion Program	57,658	0
Regular Assisted Living Program	1,579	0
State/Local Hospitalization Program	6,101	0
Uninsured Medical Catastrophe Fund	6	0

Anticipated Changes In Agency Customer Base:

Note for Agency Customer Base Listing tab: Customer figures represent the number of unduplicated enrollees or recipients for whom claims were paid during state fiscal year 2005. The potential number of customers is equivalent to the number of individuals who meet eligibility criteria (e.g., age, income level, medical condition) for each program. These figures are not known.

• Medicaid Program
Approximately 87% of the DMAS customer base is served through the Medicaid program. Average monthly enrollment in this program grew 6% in FY 2003, 9% per year in FY 2004, and 7.6% in FY 2005. The Department's current forecast projects 5.3% growth in FY 2006, 3.4% growth in FY 2007, and 2.7% growth in FY 2008 based solely on historical trends.

In addition, the number of Virginians age 65 and older is projected to increase dramatically over the next ten years, over five times faster than the state's total population growth. This growth, in turn, will increase the number of individuals receiving long-term care services and Medicare premium assistance through Virginia's Medicaid program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, known as Medicare Part D, which provides prescription drug coverage to Medicare beneficiaries. Virginians applying for Medicare Part D may find that they also qualify for Medicaid, which will increase the number of individuals served.

The increased ability of medical technology to treat severe illnesses and disabilities and prolong life will increase the Department's customer base. Statistics show that the life expectancy at age 65 has increased 12% for males and 3% for females since 1980.

Economic conditions also affect the number of individuals eligible for medical assistance services. According to the Virginia Employment Commission, the final numbers for 2004 showed strong economic growth for both the U.S. and Virginia. Continued economic growth can be expected to have somewhat of a countervailing effect on the trends noted above regarding the number of low-income Virginians needing medical assistance services.

• FAMIS, FAMIS Plus (Medicaid for Children), and Medicaid Expansion
As of July 2005, over 416,000 of the estimated 432,773 uninsured children in Virginia were enrolled in one of the Department's child health insurance programs. Since 2002, the number of children served through the FAMIS and FAMIS Plus programs has grown over 40% as a result of program reforms and aggressive outreach campaigns. While this trend is expected to continue, the growth rate is expected to slow considerably as the percentage of eligible children covered under these programs nears 100%.

• State and Local Hospitalization Program (SLH)
The number of recipients served through the State and Local Hospitalization Program has declined 11 percent over the past five years and this trend is likely to continue due to rising costs of medical services and the capped amount of funding available through the program.

• Involuntary Mental Commitment Fund
The number of individuals placed under an involuntary mental commitment has remained relatively constant over the past five years and no significant change in this population is anticipated.

• Regular Assisted Living Program
Increases in an auxiliary grant administered by the Department of Social Services will increase the eligibility for Regular Assisted Living services.

• HIV Premium Assistance Program
While there has been a decline in the number of participants over the past years, it appears it is almost entirely a result of double-digit premium increases in insurance costs and not a decrease in need for the program.

Additional funding provided for FY 2006 was quickly exhausted as a large number of applications for this program had been received A waiting list for this program has been reestablished.

• Uninsured Medical Catastrophe Fund
It is anticipated that the number of individuals served through the Uninsured Medical Catastrophe Fund will increase in future years due to three key factors: 1) a newly dedicated staff position who can manage program activities, 2) current initiatives to streamline the regulations and application process, and 3) additional funding ($125,000) provided for FY 2006. However, this is a very small program and the number of persons served is limited by the available funding.

• Indigent Health Care Trust Fund
No changes in this customer base are anticipated.

Agency Partners:

Advocacy groups
Advocacy groups that represent provider organizations or recipient groups on matters related to DMAS programs and services

Boards and committees
Boards and committees, established by statute or created by DMAS, serving in an advisory capacity in an area of subject matter expertise and/or providing assistance in the formulation of program policy

Federal agencies
Federal agencies that provide funding and oversight for the Medicaid and Title XXI programs as well as the Medicare program

Health care professionals, organizations, and facilities
Health care professionals, organizations, and facilities rendering medical services to clients of Medicaid, FAMIS, or other indigent health care programs administered by DMAS

Private business firms
Private business firms, contracted by DMAS, providing program functions including claims processing, recipient enrollment, prior authorization of medical services, brokered transportation services, cost settlement and audit reviews, managed care enrollment, and actuarial services

State and local entities
State and local entities providing medical services covered and reimbursed by Medicaid or FAMIS programs or performing various program functions (e.g., recipient enrollment)

State government officials
State government officials in both the executive and legislative branches of government who are responsible for setting agency priorities, determining health care policy, assisting DMAS deliver its services, setting DMAS' appropriation levels and enacting legislation

Agency Products and Services:

Current Products and Services

DMAS, in coordination with its partners, provides a wide spectrum of services to enable the successful operation of the agency's health care programs. For organizational purposes DMAS has identified five broad classifications of services. Long Term Care, Special Programs and FAMIS, Administration, and Operations.

• Long Term Care (LTC) and Waiver Programs
DMAS provides long term care services including coverage for nursing home care, and the development and management of waiver programs (e.g., home and community based waivers, and mental retardation waivers) that provide access to health care for special populations.

• Special Programs Not Covered by Medicaid
DMAS is responsible for several programs that have different funding and administration streams than Medicaid. These programs include a health insurance premium payment program, an indigent health care trust fund, an uninsured medical catastrophe fund, and a state and local hospitalization program.

• FAMIS – Family Access to Medical Insurance Security
FAMIS is the state's health insurance program that covers traditional health care services to uninsured children in families with incomes that exceed Medicaid levels. This program has a federal match that is separate from the Medicaid program and also has a separate state plan. Along with the provision of medical services, the program includes outreach, eligibility determination, enrollment, and policy development.

• Administration – Several administrative services support management and staff in carrying out the mission of the organization: human resources, procurement, strategic planning, workforce development, training, contract development and management, and property management.

• Operations

Health care services – DMAS provides traditional health insurance products and programs for hospital stays, outpatient services, pharmacy, labs/x-rays, mental health, dental, vision, ancillary services, equipment and supplies. DMAS also provides transportation services for Medicaid recipients.

Enrollment and member services – These services include recipient call centers, mailings to recipients, membership enrollment, and a process for recipient appeals.

Provider enrollment, services and reimbursement – These services include claims processing and reimbursement, education and training, medical support and consultation, provider call centers, mailings to providers, prior authorizations, provider and customer service, provider enrollment, network analysis, and provider appeals.

Program integrity – Functions include a) provider and recipient audits, b) compliance, fraud and utilization reviews, c) internal audits and reviews, and d) reengineering and process improvement.

Financial service – In order to manage a multi-billion dollar program, the department has established several financial functions including accounting, budget development, forecasting, rate development, financial analysis, fund management, fiscal operations, and reporting. The department also contracts with an actuarial firm to provide highly technical financial analyses.

Policy analysis and information dissemination – DMAS provides policy analysis and development;

development and promulgation of state and federal regulations, state plans and waivers; evaluation of programs; development of studies, position papers, surveys and research; quality reviews; grants development; legislative tracking and development; constituent communication; briefings to the Governor, Secretary Health and Human Resources and Legislature; website administration; media requests and interviews; and Freedom of Information Act (FOIA) requests.

Factors Impacting Agency Products and Services

The scope of the products and services provided by DMAS continues to be effected by changes taking place in the health care sector in general. These changes include, new health care technologies, the continued emphasis on treating individuals in an outpatient setting or in the community as opposed to treating individuals in the facilities, and the increasing use of care management programs to manage and improve health outcomes especially for individuals with specific conditions.

The largest factor impacting the provision of administrative services and operations is the use of technology enhancements to increase the efficiency of the programs, expedite the services that are provided by the agency and increase the access to information needed to perform policy analysis and program integrity.

Anticipated Changes in Agency Products and Services

It is expected that the provision of Long Term Care (LTC) and Waiver Programs services will continue to increase. In recent years numerous new waiver programs have been proposed which target individuals based on a specific condition/diagnosis. In addition, as the number of citizens in the Commonwealth over the age of 65 increases there will be increased demand for community based care services.

For primary health care services DMAS expects to continue to increase the number of customers who receive their health care through private managed care organizations as opposed to the Medicaid fee-for-service system.

DMAS continues to emphasize technology improvements, both through DMAS' internal operations and through companies contracted with DMAS' to provide support services to improve services provided under DMAS' operations. Specific improvements which have occurred recently or will occur in the near future are in the operation of the provider call center, the membership enrollment processes and the prior authorization process.

Agency Financial Resources Summary:

DMAS' budget is currently funded with approximately 43.0% state general funds, 50.4% federal funds and 6.6% special funds. The special funds are comprised of the Family Access to Medical Insurance Security Plan Trust Fund, Virginia Health Care Fund and Civil Money Penalties.

	Fiscal Year 2007		Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Base Budget	$2,152,985,491	$2,853,046,659	$2,152,985,491	$2,853,046,659
Changes To Base	$245,607,973	$68,024,714	$423,608,044	$263,510,464
AGENCY TOTAL	**$2,398,593,464**	**$2,921,071,373**	**$2,576,593,535**	**$3,116,557,123**

Agency Human Resources Summary:

Human Resources Overview

The Department of Medical Assistance Services is a highly professional organization with 348 authorized classified positions. As of October 10, 2006, 318 of these positions are filled and 36 are vacant. Four of the classified employees are located in the Roanoke Office; one is located in Manassas, and one is in Virginia

Beach. Because of increasing program requirements, the Department has had to use increasing numbers of hourly employees. Most of the contract employees work in the Information Management Division and play a critical role in the maintenance of the Virginia Medicaid Management Information System and any programmatic changes. The Department has 15 divisions/offices, which include the Office of the Director. Forty-one role titles are used and the most prevalent are the Health Care Compliance Specialist II (18.4%), Health Care Compliance Specialist I (13.5%), Administrative and Office Specialist III (11.6%), and Program Administration Specialist II (12.3%). We also employ workers from temporary employment agencies, such as Caliper.

Note for Human Resources Levels tab:
Temporary Agency Workers.....5

Full-Time Equivalent (FTE) Position Summary

Effective Date:	10/10/2006
Total Authorized Position level	348
Vacant Positions	30
Non-Classified (Filled)	3
Full-Time Classified (Filled)	315
Part-Time Classified (Filled)	0
Faculty (Filled)	0
Wage	84
Contract Employees	27
Total Human Resource Level	**429**

Factors Impacting Human Resources

• Increased programmatic requirements continue to necessitate the extensive hiring of hourly employees. The hourly employees serve a vital role and require the same level of training as full-time employees. However, most of these employees seek other employment with benefits. Thus, the turnover rate among the hourly workforce for this reporting period was 40.8%. The restriction of 1500 work hours per year for hourly workers also has a negative impact on productivity and retention.

• There is some concern regarding the aging workforce. The average age of the DMAS classified workforce is 47 years. As of October 10, 2006, eleven (11) employees are eligible for full retirement being age 50 with 30 years of service; four additional employees can retire with full benefits based on age. Ninety-four (94) employees (30%) are age 50 with 10 years of service and could retire with partial benefits, although most employees prefer to retire with full benefits. The positions range from upper level management to support staff. During the next five years, an additional four (4) employees will become eligible for full retirement. These figures do not include employees who have purchased prior service and may be eligible for retirement much sooner.

• The turnover rate for classified employees leaving the Department during the October 10, 2005 to October 10, 2006 period was 14 % (45) Most of these employees left the Department for advancement reasons. Of this number, 10 left the State, 15 transferred to other state agencies, 12 retired, 6 were terminated based on the Standards of Conduct Policy, and two are deceased.

Anticipated Changes in Human Resources

• Due to budget constraints, employee training has received little emphasis in past years. However, a full-time classified position was recently approved and has been filled. This position is responsible for both training and the employment process With adequate funding, it is hoped that not only will the employee training program be enhanced, but the time frames for filling positions will be expedited. To date, DMAS

is increasing the amount of employee training opportunities. Currently, a series of classes on customer service, project management, supervisory/leadership, and computer software training has been presented during the last fiscal year. This type of training is being scheduled for future training during the current fiscal year. In addition, it is planned to continue the DMAS Supervisory and Leadership Institute presented by the Community College Workforce Alliance; it will begin November 1, 2006 with a series of comprehensive supervisory and leadership classes

• We anticipate greater use of the Learning Management System both internally and with the programs offered by the Department of Human Resource Management. The Learning Management System is a Web-based system designed to present learning and knowledge sharing opportunities to its users. It promotes learning through online course offerings, classroom course registration, and a consolidated transcript of all learning events for individual users. The system DMAS has purchased is the Meridian KSI Knowledge Center (TM), but it is mainly used for provider training. Currently, we are members of the DHRM LMS Users group and will be implementing on-line access to the DHRM LMS Knowledge Center.

• It is anticipated that there will be improvement in automated databases provided by the Department of Human Resource Management and the Department of Accounts.

• The Maximum Employment Level was recently raised to 348 positions, but there is a continuing need to use hourly employees to meet programmatic needs. Of the current thirty-six (36) vacant classified positions, all are either in some stage of the recruitment and selection process or under classification review. A high frequency rate of internal transfers and promotions seems to keep the vacancy rate consistently high.

• Even though the turnover rate is not as high in DMAS as in some other agencies, retention of highly skilled employees must be emphasized through effective employee recognition programs, training, and fair and consistent compensation practices.

Agency Information Technology Summary:

Current State / Issues

• The current period of the Medicaid Management Information System (MMIS) fiscal agent contract will end on June 30, 2008. There are two remaining option years allowed under the contract.

• The Third Party Liability System Recovery System (TPLRS) is running on a hardware platform that is aging and will exceed lifetime expectancy guidelines in this period.

• The Program Operations Division has identified customer service improvements that they would like to initiate that will require Information Technology support.

• DMAS operates a mission-critical function using the Oracle Government Financials system. The Agency needs to support the system through required maintenance and enhancements as well as any product upgrades.

• The network infrastructure, servers, desktop workstations, and applications that are used by DMAS staff must be maintained and kept current. This makes up the Information Retrieval Platform (IRP) at DMAS, which is a component of the MMIS.

Factor Impacting Information Technology

• HIPAA Transactions, Code Sets and Identifiers Rules require ongoing compliance to standardization of electronic data interchange (EDI). The following actions relate to this issue.

O The National Provider ID (NPI) is mandated to become the primary identifier for health care individuals and organizational entities. Electronic standard transactions will be impacted by the change to this identifier for identifying servicing and billing provider entities

• Electronic Health Record (EHR) is a 10-year Presidential initiative to allow interoperability for sharing healthcare data between systems. Virginia has a Governor's initiative to explore the development and use of an "EHR".

Anticipated Changes / Desired State

• The solution for the National Provider Identifier (NPI) will be to change the databases and EDI extractions to use either NPI or Legacy identifiers in the Medicaid Management Information Systems (MMIS) during a transition period leading up to the mandatory compliance date. By the May 23, 2007 compliance date, a final modification will be made to the MMIS relationship structure of the databases to use only the NPI as the primary identifier that is linked with the required variables. MMIS software program logic will be modified to handle both the aforementioned steps.

• A process of accessing provider credentials and information from the CMS NPPES will be integrated into the DMAS Provider Enrollment Process for cross validation of NPI data and provider credentialing.

• Development and use of data for an Electronic Health Record will be done. Exchanges of information for state and/or federal data sharing would need to be accommodated. In addition, a decision support system would require secure access as well as possible data update capability.

Anticipated Changes / Desired State

• The Information Management Division will continue to coordinate regular reviews of the performance of the MMIS fiscal agent contractor (First Health Services Corporation) and evaluate the results to make a recommendation regarding the advantages and disadvantages of exercising the two option years which can be extended through 6/30/10 if the two option years are exercised. As part of a due diligence effort, DMAS is anticipating the use of functional consultants to assist in a competitive procurement, which could include the functional and business resources for planning, transitioning, testing, implementation and validation activities that would be part of a new Fiscal Agent contract.

• The hardware platform used to run the Third Party Liability Recovery System (TPLRS) will be replaced with a more state-of-the-art system to increase maintainability and efficiency and reduce risk of hardware failure.

• The Information Management Division will work with the Program Operations Division to identify web-based applications that can be developed to improve customer services for MMIS providers. Anticipated improvements include features such as direct data entry of claims, accessing remittance advices on the Web, interactive on-line documentation, and broadcast e-mail capabilities.

• The Information Management Division will maintain and enhance the Oracle Government Financials system to support the requirements of the Agency and Commonwealth. Vendor upgrades to the software application will also be monitored and upgrades will be evaluated, scheduled, and performed as needed.

• The Information Management Division will continue to maintain the network infrastructure, servers, desktop hardware and software used by DMAS staff. Upgrades to IT resources will be evaluated, recommended, procured, and applied as needed to meet DMAS' mission and changing technology.

Agency Information Technology Investments:

	Cost-Fiscal Year 2007		Cost-Fiscal Year 2008	
	General Fund	Nongeneral Fund	General Fund	Nongeneral Fund
Major IT Projects	$0	$0	$0	$0
Non-Major IT Projects	$0	$0	$0	$0
Major IT Procurements	$2,807,533	$10,278,339	$2,606,744	$7,835,527
Non-Major IT Procurements	$1,115,378	$2,619,183	$1,506,251	$3,102,037
Totals	**$3,922,911**	**$12,897,522**	**$4,112,995**	**$10,937,564**

Agency Goals

Goal #1:

Facilitate the development of public health care policies that promote access to care and the efficient, effective, innovative delivery of covered services.

Goal Summary and Alignment:

The mission of the Department of Medical Assistance Services (DMAS) is to provide eligible individuals with access to needed health care. DMAS plays an important role in providing this access and in influencing policies that extend access to those most in need.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #2:

Promote better health outcomes through prevention-based strategies and improved quality of care.

Goal Summary and Alignment:

Although DMAS does not directly provide health care services, it does have a role in ensuring that those who are eligible for its services receive quality health care. DMAS believes that a focus on prevention-based strategies will reap positive health benefits for its clients and sound fiscal benefits for taxpayers.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #3:

Enhance the delivery of health care services by improving communication and relationships with customers and partners.

Goal Summary and Alignment:

Effective communication is vital to ensure that DMAS' partners understand the administrative/legal aspects of DMAS services, as well as the outcomes DMAS is striving to achieve on behalf of its clients. Equally important is the dissemination of information to eligible and enrolled individuals who ultimately benefit from these important services.

This goal supports the Council on Virginia's Future Long-Term Objective #5: Inspire and support Virginians toward healthy lives and strong and resilient families.

Goal #4:

Create a positive work environment that promotes staff development and training, facilitates effective communications and rewards high levels of performance.

Goal Summary and Alignment:

A good work environment helps to create satisfied employees who, in turn, create satisfied customers and partners. DMAS strives to provide the best possible work environment for its staff members by recognizing accomplishments, expanding the knowledge base of staff members and maintaining open lines of communication to ensure the workforce has the information it needs to effectively accomplish the organization's goals.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation.

Goal #5:

Maintain a system of internal controls that adequately protects resources from fraud, waste and abuse.

Goal Summary and Alignment:

DMAS is responsible for managing a multi-billion dollar enterprise. Sound fiscal management and strict compliance with accepted financial standards and controls is essential for protecting these resources. DMAS will continue to rigorously examine the way it operates to reduce waste and to prevent fraud and abuse.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation

Goal #6:

Improve operational efficiency and enhance data management through innovation and utilization of industry best practices.

Goal Summary and Alignment:

A hallmark of any well-managed organization is its desire to continually examine the way it works in order to find ways to improve effectiveness and efficiency. To accomplish this, DMAS will search for best practices within and outside of the health care industry and state government and will strive to develop innovative approaches for delivering services to its clients.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation.

Goal #7:

Encouraging support of minority business development throughout the Commonwealth and strive to continue improving direct and indirect minority business relationships in the future.

Goal Summary and Alignment:

Executive Order 33 (2006) directs cabinet secretaries and all executive branch entities to increase small, women and minority-owned business participation throughout the Commonwealth. DMAS - in its Annual SWaM Procurement Plan - set a goal of 50% SWaM participation overall (5% with prime contractors and 45% with subcontractors). The agency will continue to seek out SWaM vendors as procurement opportunities arise.

This goal supports the Council on Virginia's Future Long-Term Objective #1: To be recognized as the best managed state in the nation.

Statewide Goals Supported by Goal #7

- Be recognized as the best-managed state in the nation.